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THE CHILD'S NOTEBOOK AS A PUBLIC HEALTH TOOL: A NARRATIVE REVIEW

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ABSTRACT

The Child's Notebook (CC) is a tool that reflects the evolution of public health policies in Brazil, serving as an important instrument for monitoring child growth and development. It integrates with various government programs to ensure continuous and multidisciplinary monitoring of child health. This narrative review aims to present the historical context of public policies that contributed to the development of the CC and the evolution of previous instruments. In 1940, with the creation of the National Department of Children (DNC), the promotion of child well-being became part of the public agenda. In 1984, the Comprehensive Assistance Program for Children's Health (PAISC) launched the Child Card, unifying information related to child health. However, it was in the 1990s, with the enactment of the 1988 Statute of the Child and Adolescent (ECA), that the rights of children and adolescents were recognized, granting them priority in access to social policies. In 2004, the Agenda of Commitments for Comprehensive Child Health and the Reduction of Infant Mortality was launched, and the following year, the Child's Health Record Booklet (CSC) was distributed nationwide as an important instrument for promoting health and reducing infant mortality. Thus, the evolution of public health policies and the strengthening of the Health Care Networks highlight the CC as an emblematic example of child health promotion and the shared responsibility between families and healthcare professionals.

Keywords: Personal Health Records; Comprehensive Health Care; Child Health Services.

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INTRODUCTION

The trajectory of child health in Brazil is marked by a series of structural transformations and legislative advances, particularly driven by the expansion and enhancement of public policies and the establishment of innovative instruments for monitoring child development. The central role of these instruments, especially the Child's Notebook (CC), reflects the articulation between intersectoral policies and the constitutional guarantee of children's rights, promoting the longitudinal monitoring of child growth and development as established by the 1988 Federal Constitution and the Statute of the Child and Adolescent (Estatuto da Criança e do Adolescente, ECA) (BRASIL, 1988; BRASIL, 1990).

Historically, child healthcare in Brazil originated within the philanthropic sector and progressively shifted to the state sphere from the mid-20th century onward, in response to high infant mortality rates and the need to consolidate systematic actions for the prevention and promotion of health among this vulnerable population group (ARAÚJO *et al*., 2014). Programs such as Rede Cegonha, the Family Health Program (Programa Saúde da Família, PSF), and the National Policy for Comprehensive Child Health Care (Política Nacional de Atenção Integral à Saúde da Criança, PNAISC) represent milestones in the institutionalization of pediatric care and health surveillance, incorporating the CC as a fundamental tool for documentation and monitoring, both within the context of primary care and in health education and immunization initiatives (BRASIL, 2018).

The uniqueness of this review lies in its proposal to historically consolidate the trajectory of public policies that culminated in the development and ongoing evolution of the CC, systematically mapping its predecessor instruments as well as the legal and programmatic strategies implemented over the decades. Differentiating itself from existing reviews, which typically focus on specific aspects of the CC use or isolated sectors of child healthcare, this study conducts a comprehensive narrative analysis, highlighting the integrative role of the CC in promoting comprehensive care and strengthening the bond between families, healthcare professionals, and public authorities.

By establishing the child as a rights-holder, the CC occupies a central position in health surveillance strategies, being indispensable for monitoring growth, vaccination, disease screening, and fostering family participation in care activities, despite persistent challenges related to professional training and family adherence (BRASIL, 2024a).

Thus, this work aims to fill a gap identified in Brazilian literature by consolidating the historical trajectory of public policies related to childhood, emphasizing the importance of institutional coordination and the leading role of the CC in promoting child health and realizing the fundamental rights of this population.

HISTORICAL CONTEXT OF SOCIAL POLICIES FOR CHILDHOOD IN BRAZIL

Until the early decades of the 20th century, philanthropic institutions were primarily responsible for providing assistance to children. It was only in the 1920s that public and private authorities began to debate child health. At that time, children, considered dependents of industrial workers, received medical care based on the practices of physicians hired by industrial proprietors. Discussions about the benefits of breastfeeding and disease prevention emerged during this period, particularly because sick children contributed to increased absenteeism in industries (ARAÚJO *et al.*, 2014).

During the Estado Novo (New State) period, the first government sector dedicated to child welfare was created: the Departamento Nacional da Criança (National Department of Children, DNC), in 1940. The DNC was part of a universalist approach to health under the newly established Ministry of Education and Public Health (Ministério da Educação e Saúde Pública, MESP). This development marked a significant milestone in the history of maternal and child health policies in Brazil. From this point forward, promoting child welfare became an official government agenda, closely associated with the nation-building project of the Vargas administration (LOPES; MAIO, 2018).

In 1953, the MESP was divided into the Ministry of Education and the Ministry of Health (MH). After this division, the MH assumed responsibility for the DNC, which was replaced in 1970 by the Coordination for Maternal and Child Protection. During this historical period, Brazil faced a high infant mortality (IM) rate, prompting the implementation of the National Maternal

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and Child Health Program (PNSMI), aimed at reducing morbidity and mortality among children and mothers. However, despite these actions, significant changes in IM rates were not observed by the end of the decade (ARAÚJO *et al.*, 2014).

In the two decades preceding the 1988 Federal Constitution, several initiatives had a significant impact on improving health and reducing infant and child mortality. A notable milestone was the establishment of the National Immunization Program (Programa Nacional de Imunizações, PNI) in 1973, which expanded vaccination coverage, particularly among children. In the realm of social control, the inclusion of maternal and child health as a program in the V National Health Conference in 1975 marked the first time this issue was formally incorporated into the discussions of health councils. This agenda emerged as a fundamental aspect of social control and became a cornerstone of public and collective health policy in Brazil (PAIM, 2015). Additionally, in 1981, the National Program for the Promotion of Breastfeeding (Programa Nacional de Incentivo ao Aleitamento Materno, PNIAM) was launched, coordinating strategies to protect and promote breastfeeding across the country (BRASIL, 2018). These initiatives laid the groundwork for subsequent advancements in maternal and child health within Brazil's public health system.

In 1983, the Comprehensive Assistance Program for Women's and Children's Health (Programa de Assistência Integral à Saúde da Mulher e da Criança, PAISMC) was launched, aiming to implement actions to improve health conditions, expand coverage, and enhance the public healthcare network. The program outlined five core actions for addressing the health needs of Brazilian children: promoting breastfeeding and providing family guidance on nutrition during weaning; strategies for controlling acute respiratory infections; basic immunization; effective management of diarrheal diseases; and professional monitoring of child growth and development. In 1984, the PAISMC was divided into two separate programs: the Comprehensive Assistance Program for Women's Health (Programa de Assistência Integral à Saúde da Mulher, PAISM) and the Comprehensive Assistance Program for Children's Health (Programa de Assistência Integral à Saúde da Criança, PAISC). PAISM focused on women's health, while PAISC addressed child health, prioritizing children in high-risk groups. PAISC aimed to improve care quality, increase healthcare service coverage, and promote holistic health promotion actions for children (BRASIL, 2016, 2018).

The principles established in the 1988 Federal Constitution served as the foundation for drafting the ECA, enacted on July 13, 1990, through Law No. 8,069. The ECA is considered one of the most progressive legal frameworks in the world concerning the rights of children and adolescents. While the Constitution recognized children as rights-holders, the ECA solidified the principle of comprehensive protection. For the first time, children and adolescents were formally acknowledged as citizens, guaranteeing their rights and establishing their absolute priority in accessing social policies (BRASIL, 2018; FUNDAÇÃO ABRINQ, 2021).

Health humanization policies took on a new direction beginning in the 1990s. The implementation of the Community Health Agents Program (Programa de Agentes Comunitários de Saúde, PACS) in 1991 and the PSF in 1994 by the MH significantly enhanced child health initiatives. During this decade, several humanization programs aimed at improving healthcare quality were developed and implemented, such as the Perinatal Health Assistance Program (Programa de Assistência à Saúde Perinatal, PROASP), the Baby-Friendly Hospital Initiative (Iniciativa Hospital Amigo da Criança, IHAC), and the Kangaroo Method (ARAÚJO et al., 2014; BRASIL, 2004).

This set of changes and actions was instrumental in transforming childhood health in Brazil, leading to a significant reduction in infant mortality rates. However, the progress fell short of meeting the country's needs, underscoring the necessity for a paradigm shift toward health promotion and comprehensive child care. To address this, the Agenda of Commitments for Comprehensive Child Health and the Reduction of Infant Mortality was launched in 2004. A year later, the Child's Health Record Booklet (Caderneta de Saúde da Criança, CSC) was distributed nationwide as a critical tool to support this shift (BRASIL, 2004).

In 2006, a historical milestone for maternal and child health was the formulation of the Operational Guidelines for the Pacts for Life, Unified Health System (SUS) Defense, and Management. Within the Health Pact, the National Primary Healthcare Policy (Política Nacional

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de Atenção Básica, PNAB) identified child health and the elimination of child malnutrition as strategic areas. Among the goals set in the Pact for Life, reducing infant mortality was identified as a strategic target. However, paradoxically, the use of the CSC was only mentioned in the document concerning the elderly, revealing a critical gap in recognizing its potential as a tool for promoting child health. This discrepancy reflects the restrictive priorities and perspectives regarding the use of this instrument at the time and warrants a critical analysis of its underutilization in advancing child health initiatives (BRASIL, 2006).

Between 2004 and 2013, the implementation of programs such as Zero Hunger (Fome Zero) and the Bolsa Família Program (PBF) significantly improved food security in Brazil. The direct income transfers to families living in poverty and extreme poverty were instrumental in combating hunger and food insecurity. Furthermore, the creation of the National School Feeding Program (Programa Nacional de Alimentação Escolar, PNAE) in 2009 provided healthier meals to more than 40 million students (COTTA; MACHADO, 2013; PEREIRA *et al.*, 2020).

In the same year, Ministerial Ordinance No. 2,395/2009 established the Healthy Brazilian Boys and Girls Strategy – First Steps for National Development (Estratégia Brasileirinhas e Brasileirinhos Saudáveis, EBBS). This initiative, developed by the Oswaldo Cruz Foundation (Fiocruz) in collaboration with the MH, aimed to strengthen public policies for early childhood protection, aligning with the recommendations of the World Health Organization (WHO) and the National Commission on Social Determinants of Health (CNDSS). This strategy introduces a distinct political perspective, linking the healthy, full, and robust development of Brazilian children with the construction of their citizenship and the sustainable development of the country (BRASIL, 2013; PENELLO, 2015).

Ministerial Ordinance GM/MS No. 4,279, issued on December 30, 2010, established guidelines for organizing Health Care Networks (Redes de Atenção à Saúde, RAS) within the SUS. These networks represent organizational arrangements of health actions and services with varying levels of technological density, aiming to promote systemic integration for continuous, comprehensive, quality, responsible, and humanized care. This new service planning model globally programs an articulated set of services in defined territories (health regions) and has a unique feature: its communication hub is located in Primary Health Care (PHC) (BRASIL, 2022a).

Within the RAS framework, the MH prioritized the organization of the maternal and child health thematic network. In this context, the Rede Cegonha was established by Ordinance No. 1,459 on June 24, 2011, focusing on prenatal care, childbirth, postpartum, and care for children up to two years of age. The network was structured into four components: prenatal care, childbirth and birth, postpartum and comprehensive child healthcare, and a logistical system for health transport and regulation (BRASIL, 2013).

To reinforce policies related to health, education, and income for early childhood, the Brasil Carinhoso Program was launched in 2012. This program provided financial resources to cover expenses for early childhood education development, food security, and nutrition, while ensuring children's access to and retention in early education. In health, the program aimed to prevent and treat conditions that impede early childhood development, such as vitamin A and iron deficiencies, anemia, and asthma (BRASIL, 2015).

Integrated into the Rede Cegonha, the National Strategy for Breastfeeding Promotion and Healthy Complementary Feeding (Estratégia Amamenta e Alimenta Brasil, EAAB), launched in 2012, sought to enhance actions promoting breastfeeding and healthy complementary feeding for children under two years of age. This strategy focused on continuous education for health professionals as a routine in Primary Care Units (PCU). Despite progress, breastfeeding rates in Brazil remain below the WHO targets of at least 50% exclusive breastfeeding by 2025 and 70% by 2030 (BRASIL, 2015).

In 2015, the PNAISC was established by Ordinance No. 1,130 on August 5, 2015. This policy marked a milestone in comprehensive child care, integrating actions across all levels of care. It was structured around principles, guidelines, and seven strategic axes aimed at guiding and enhancing child health actions and services nationwide. The PNAISC considers social determinants and conditions to ensure the right to life and health, reducing morbidity and mortality, and fostering environments conducive to dignified living and

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full development. The PNAISC emphasizes the importance of the CSC as an essential tool for child health surveillance. It mandates its widespread distribution, ensuring every Brazilian child born in public or private maternity facilities receives it (BRASIL, 2018; BRASIL, 2015; MACÊDO, 2016).

Law No. 13,257, known as the Legal Framework for Early Childhood in Brazil, was enacted on March 8, 2016, establishing a series of guidelines and actions aimed at promoting the comprehensive development of children up to six years of age. This law recognizes the importance of the early years of life for human development. A few months later, the Happy Child Program (Programa Criança Feliz, PCF) was established by Decree No. 8,869 on October 5, 2016, in alignment with the guidelines of the Legal Framework for Early Childhood. The program's goal is to promote the holistic development of children in early childhood through two main components: (I) Home visits and (II) Integration of early childhood care policies within the community. Home visits constitute the principal strategy for connecting services with the families being served. These visits aim to address the specific needs of each family's context, resulting in tailored intervention proposals. Through these visits, the integration of the PCF with other early childhood care policies is fostered. The visitor identifies situations requiring intervention and refers the child or family to the appropriate services, including monitoring the CSC (BRASIL, 2017; MINISTÉRIO DA SAÚDE, 2024).

It is noteworthy that in 2017, the PNAB was updated, establishing home visits as a shared responsibility among all members of the Family Health Strategy (Estratégia Saúde da Família, ESF) teams, with a central role assigned to the Community Health Agent (Agente Comunitário de Saúde, ACS). This guideline reinforces the practice as a fundamental strategy for fostering the connection between families and health services while expanding the reach of PHC in its mission to provide comprehensive and continuous care. This update highlights the commitment to comprehensive care, strengthening the monitoring of early childhood and coordinating actions such as those promoted by the PCF and other child health policies (BRASIL, 2017).

With the onset of the COVID-19 pandemic in March 2020, existing social inequalities and vulnerabilities deepened further, especially for children, within a context of political and economic instability (MATTA *et al.*, 2021). The decline in household income due to social isolation measures and the difficulty in accessing water and food prompted the adoption of socio-economic support programs during the pandemic, such as the Emergency Aid (Auxílio Emergencial). In the months following its implementation, the proportion of children living in poverty and extreme poverty decreased from 40% to 35%. However, after the benefit was reduced, this rate rose again to 39% (NASSIF-PIRES; CARDOSO; OLIVEIRA, 2021).

In addition to these challenges, significant changes occurred in maternal and child healthcare policies during this period. The replacement of the Rede Cegonha by the Maternal and Child Care Network (Rede de Atenção Materno Infantil, RAMI) in 2022 marked a turning point in the model of care for the pregnancy-puerperal cycle in Brazil, shifting the focus from comprehensive, territorially based care to a structure more centered on gestational risk and medium- and high-complexity services (BRASIL, 2022c). While Rede Cegonha sought to ensure access, reception, and resolutive care for pregnant women and children up to two years of age through coordination across levels of care, RAMI introduced a separation between low- and high-risk care, reinforcing the perception of childbirth as a potentially pathological event and restricting the operation of Normal Birth Centers and birth houses, even when managed by nurse-midwives and midwives. This reorganization led to a reduction in the role of PHC and an increased centrality of hospital-based, curative care, contradicting the purpose of the (RAS) to strengthen primary care and reduce demand for specialized services (MORTELARO *et al.*, 2024).

In this context, the creation of the Alyne Network (Rede Alyne) in September 2024 emerges as both a political and symbolic response to the need to restructure maternal and child healthcare, reclaiming principles from the Rede Cegonha while incorporating an intersectional approach. Its name honors Alyne Pimentel, a Black woman whose preventable death led to Brazil's international condemnation by the United Nations. The initiative seeks to ensure humane and high-quality care for pregnant and postpartum women, newborns, and children, with an emphasis on reducing maternal and child morbidity and mortality, particularly among Black and

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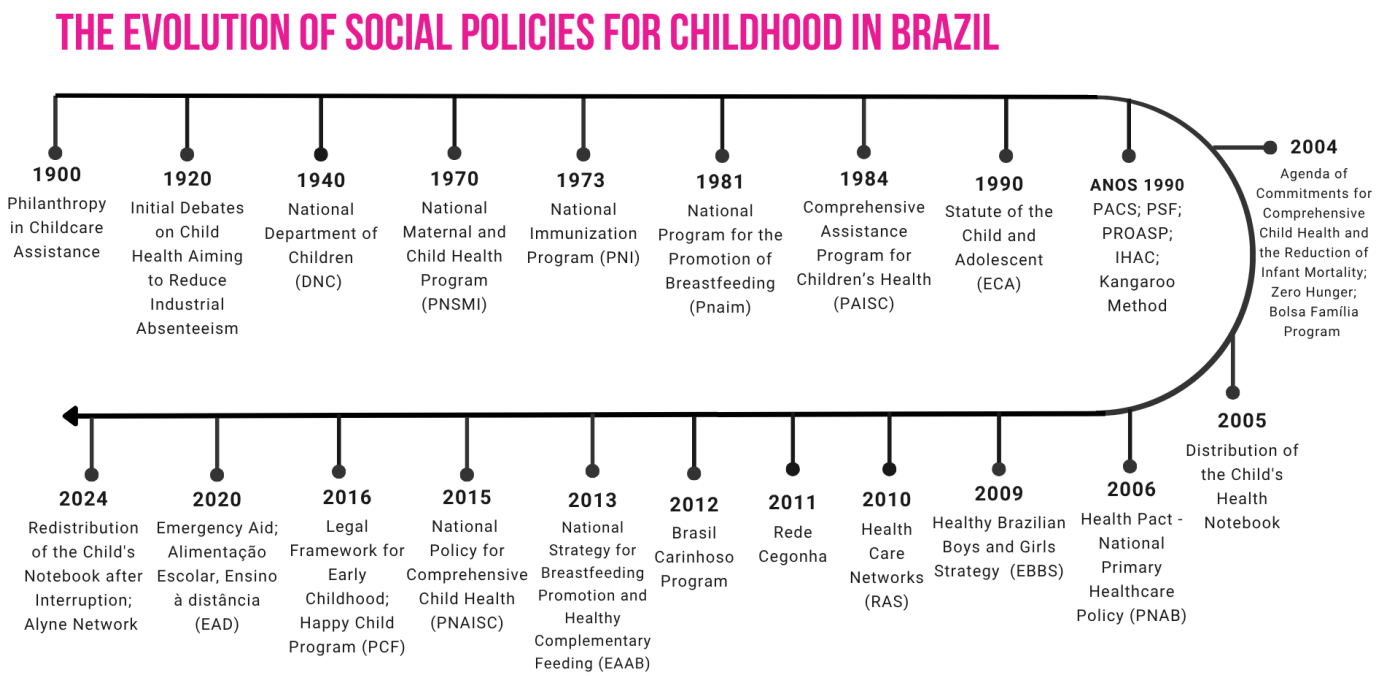
Indigenous populations. Furthermore, it aims to expand access to reproductive healthcare, strengthen the obstetric and neonatal network, and effectively coordinate the different levels of care, reinstating PHC as the central axis of care delivery (BRASIL, 2024b; 2024c).

Expectations surrounding the Rede Alyne include overcoming the shortcomings left by RAMI, particularly regarding the fragmentation of care and the exclusion of humanized approaches in low-risk childbirth. By prioritizing territorialization, equity, and dialogue between primary and specialized care, the Rede Alyne represents an opportunity to rebuild a maternal and child healthcare model that is truly comprehensive, safe, and culturally sensitive, incorporating historical lessons on gender, racial, and class inequalities in reproductive health (BRASIL, 2024b; MORTELARO *et al.*, 2024).

Historically, children have suffered from the denial and invisibility of their rights, a reality that became even more evident during the social isolation period. School closures, reduced vaccination coverage, increased domestic violence, and heightened levels of poverty, hunger, and food insecurity exacerbated the situation. These factors have had significant physical and mental health impacts on children, with repercussions likely to manifest in the short, medium, and long term (ANDRES *et al.*, 2023). Figure 1 presents a timeline highlighting major historical milestones and public policies aimed at the protection and promotion of child health over recent decades, illustrating both advances and challenges in Brazil.

Figure 1. The evolution of Social Policies for childhood in Brazil.



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THE EVOLUTION OF THE TOOL: FROM THE CHILD CARD TO THE CHILD'S NOTEBOOK (CC)

In children, growth is considered one of the best indicators of health and nutrition, reflecting the interaction of numerous endogenous and exogenous determinants. The first widely used international reference chart, recommended by the WHO, was the Harvard Growth Curve. This curve was derived from cross-sectional studies conducted with Caucasian children from Boston, USA, between 1930 and 1956. It included weight-for-age, height-for-age, and weight-for-height indices for children under 36 months of both sexes, as well as the first two indices for individuals aged 2 to 18 years (FERREIRA, 2012).

In 1959, the Road to Health Chart was developed by Morley and initially introduced in West Africa. This tool was designed for use by health agents with limited literacy skills in areas where qualified healthcare professionals were scarce. In addition to anthropometric measurements, it encouraged the recording of significant events such as weaning, the birth of a sibling, immunizations, and severe illnesses. The Road to Health Chart represented the first step in developing national strategies for regular monitoring of child growth and served as inspiration for national tools such as the Child Card (Cartão da Criança), the Child's Health Record Booklet (CSC), and the Citizenship Passports (MORLEY, 1982; MORLEY; ELMORE-MEEGAN, 2000).

The creation of the PAISC in 1984 led to the introduction of the Child Card, aiming to unify the health information provided to families and foster active participation of families and communities in promoting their own health. This card was designed to be filled out by any member of the healthcare team (not exclusively physicians), and its content was to be thoroughly explained to the child's caregiver. The instrument included a growth monitoring chart for children aged 0 to 5 years, employing the "Weight-for-Age" nutritional indicator. Separate charts were printed for boys and girls to account for minor variations in normal weight references between sexes. The growth curve reference was based on the 1977 National Center for Health Statistics (NCHS) study, with the 10th percentile chosen as the cutoff point due to its high sensitivity for diagnosing childhood malnutrition (BRASIL, 2016).

By the late 1980s, criticisms emerged concerning the percentile limits and inappropriate statistical methods used to describe growth patterns and variability. In response, the NCHS published a revised growth reference in 2000 through the Centers for Disease Control and Prevention (CDC). This update incorporated 14% of Black youth in the sample and introduced additional indices, such as "Body Mass Index (BMI)-for-Age," across all age groups. Despite these adjustments, the revised curve was still considered suboptimal, as the studied population was exclusively from the United States, did not include children born with low birth weight, and did not necessarily represent those exclusively breastfed (FERREIRA, 2012).

In the 1990s, a second version of the Child Card was introduced by the Brazilian MH, maintaining the same growth monitoring curve as its predecessor. This updated version incorporated additional features, including a section on children's rights, recommendations for child care, promotion of breastfeeding, guidelines for developmental stimulation, and accident prevention strategies. It also included a simplified developmental evaluation framework for children up to four years old, using developmental milestones as reference points (BRASIL, 2022b).

In February 2005, the CSC was launched to replace the Child Card. The CSC was designed as a more comprehensive document to enhance child health surveillance. To improve family understanding of the child's nutritional status, a color-coded system (red, yellow, and green) was introduced while maintaining an emphasis on the slope of the weight-for-age growth curve, which was extended to monitor growth up to seven years of age. Other significant updates included: introduction of a head circumference growth chart for the first year of life, guidelines for healthy eating and nutritional recommendations, tips on general health and accident prevention, and space for documenting clinical events and treatments. These advancements aimed to improve health monitoring and promote integrated care for children, reflecting a commitment to early childhood development and well-being (BRASIL, 2009).

In 2007, the CSC underwent further improvements, resulting in a more comprehensive document comprising 82 pages, widely recognized as the Citizenship Passport for young Brazilian citizens. This

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iteration incorporated the most recent updates and introduced new features, including: spaces for recording the child's medical record number at the primary care unit and updates for address changes, detailed information on birth, neonatal screening, and feeding practices at hospital discharge, clarification of the rights of parents and children, such as the provision of free birth registration, expanded guidance on breastfeeding, including key care practices for the first days of life, extension of head circumference evaluation to two years of age, and inclusion of height in the growth monitoring charts, extending growth tracking up to 10 years of age (BRASIL, 2007).

In 2009, the Citizenship Passport was updated to include a table of contents, facilitating navigation for both mothers and healthcare professionals. This version introduced additional information, such as: enhanced guidance for the first days of life, emphasizing the importance of breastfeeding, illustrations demonstrating proper breastfeeding techniques and instructions on manual milk expression for working mothers, discussions on the significance of iron and vitamin A supplementation, expanded sections on oral health, as well as ocular and auditory care, age-specific accident prevention strategies, guidance on addressing violence against children and adolescents, and indicators of danger signs in dehydration and diarrhea. These updates not only broadened the scope of the CSC but also strengthened its utility as a tool for health promotion, disease prevention, and comprehensive child care (BRASIL, 2009).

For the first time, the CSC introduced a dedicated section aimed at healthcare professionals, providing guidance on the importance of monitoring child development and the most effective methods for evaluation. This section not only highlights developmental milestones for each age but also describes the appropriate techniques for assessing them. Additionally, the CSC offers recommendations for actions to be taken if a developmental delay or abnormality is suspected during the evaluation (BRASIL, 2009).

At this stage, the WHO recommended the use of Z-scores instead of percentiles for growth curve assessments. The updated CSC assists healthcare professionals in correlating these two evaluation standards. The CSC adopts the WHO growth charts for children aged 0 to 10 years, replacing the National Center for Health Statistics (NCHS) charts previously used for children older than five years. Another significant improvement is the inclusion of a BMI table based on the child's weight and height, eliminating the need for manual calculations. The evaluation criteria were also revised. Instead of categorizing children as undernourished, having an ideal weight for age, or obese, the CSC now uses classifications such as obese, overweight, at risk of overweight, appropriate BMI, thinness, and severe thinness. The CSC emphasizes the importance of monitoring blood pressure during pediatric consultations. It also includes dedicated spaces for recording oral health procedures and incorporates visual aids to assist non-dentist professionals in providing basic dental care guidance (BRASIL, 2015).

The instrument was developed by a team of experts with extensive experience in child growth and development. Its creation was carried out through an intersectoral collaboration involving the Ministries of Citizenship and Education and was subjected to a public consultation in December 2015 (CAVALCANTI; LUCENA; LUCENA, 2015).

Until 2018, the material was referred to as the CSC and had undergone 12 editions. However, in 2019, following modifications to its content, it was renamed the CC to reflect its broader scope, encompassing sectors beyond health, particularly social assistance and education. In 2020, the second edition of the revised CC was published exclusively in digital format, featuring minor formatting adjustments and updates (BRASIL, 2022b).

The first section of the CC is primarily aimed at families and caregivers, providing guidance on child health, parental rights, birth registration, breastfeeding, healthy nutrition, vaccination, growth and development, warning signs of severe illnesses, and the prevention of violence and accidents. The second section is tailored for healthcare professionals, focusing on recording critical child health information, growth charts, developmental surveillance tools, and tables for documenting administered vaccines.

Although the change in nomenclature to the CC broadened its intersectoral scope by including sections dedicated to education and social assistance, studies indicate that the effective implementation of this integration still faces practical barriers (BRASIL, 2022b).

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A scoping review of studies on the CC identified widespread weaknesses in its completion and use, highlighting, among the limiting factors, the need for continuous professional training and localized interventions (TEIXEIRA *et al*., 2023). Furthermore, experiences with intersectoral policies, such as the School Health Program, reveal that coordination with sectors such as education and social assistance encounters challenges including partial coverage, lack of dissemination, work overload, and shortages of human resources and infrastructure (RUMOR, 2022).

The third edition, published in 2021, introduced the M-CHAT-R/F Checklist, a tool designed to assist in identifying children aged 16 to 30 months with potential Autism Spectrum Disorder (ASD). The application of this questionnaire has been mandatory during pediatric follow-up consultations provided by the SUS since 2017. The tool is quick to administer, can be utilized by any healthcare professional, and is completed by parents or caregivers during the consultation. Additionally, information was included to guide parents and caregivers on recognizing signs of albinism, a dermatological condition requiring specific care (BITTAR, 2022; BRASIL, 2022b).

More recently, in April 2024, the MH launched the sixth edition of the CC during the centennial celebrations of the National Institute of Women's, Children's, and Adolescents' Health Fernandes Figueira (IFF/Fiocruz) in Rio de Janeiro. According to the Ministry, the physical version of the record, which had been discontinued for four years, will be printed and distributed again in the current year. The Minister of Health, Nísia Trindade, emphasized that the release of the sixth edition marks the restoration of a fundamental right for children and their families. This latest edition incorporates COVID-19 vaccines into the National Vaccination Schedule while maintaining its intersectoral approach with information on social assistance and education (MINISTÉRIO DA SAÚDE, 2024).

Recently, in April 2025, the MH launched the digital version of the CC, integrated into the “Meu SUS Digital” application. This initiative aims to facilitate access for parents, guardians, and healthcare professionals to essential information regarding child growth, development, and immunization. The digital record enables real-time monitoring of clinical data, the sending of vaccination alerts, and the documentation of developmental milestones, thereby promoting safer and more interactive child health management. It is important to note that the physical version of the CC continues to be distributed in healthcare units, serving as a complement to the digital format (BRASIL, 2025a; 2025b). Figure 02 illustrates the evolution of this instrument in Brazil, from the introduction of the Child Card in 1984 to the most recent edition, incorporating the digital version in 2025.

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Figure 2. The Evolution of the Child's Notebook in Brazil.

FUTURE DIRECTIONS

One of the obstacles identified in the present review concerns the low adherence to completing the CC among PHC professionals, as well as the occasional unavailability of this instrument due to interruptions in its provision by the MH. In addition, it is important to emphasize that undergraduate training programs do not provide sufficient knowledge or practical skills regarding the CC, including its completion. Inadequate record-keeping in the CC underscores the need to enhance healthcare professional training, fostering a deeper understanding of the instrument's relevance within the framework of health surveillance (SOARES *et al*., 2025)

Despite its well-established importance as an instrument for child health surveillance, the CC still faces significant challenges that limit its full potential. In light of this scenario, it is essential to reflect on strategies that could strengthen its use. One such measure would be to incorporate more comprehensive instruction on the CC and its completion into undergraduate health professional curricula. Furthermore, PHC managers should emphasize the importance of completing the CC to all members of the ESF's multidisciplinary team.

The current development of the digital version of the CC, integrated into SUS information platforms, represents a promising advancement that may facilitate real-time recording and broaden family access. International experiences, such as the child electronic health record systems implemented by the United Kingdom's National Health Service and in Australia, demonstrate that digitalization can significantly enhance longitudinal monitoring of child development, provided it is accompanied by professional training and policies that ensure digital equity. Therefore, technological advancements, combined with intersectoral strategies and educational initiatives, represent an essential frontier for improving the use of the CC and strengthening its role in the comprehensive care of child health in Brazil.

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CONCLUSION

The trajectory of evolution in public health policies, coupled with the development of monitoring tools and the strengthening of the RAS, demonstrates significant progress in Brazil's efforts to promote child health. In this context, the CC stands out as an emblematic example of this evolution, integrating essential information for monitoring child growth and development, while promoting shared responsibility between families and healthcare professionals in the care of this population.

However, it is important to highlight that challenges remain, such as the inappropriate replacement of comprehensive tools with simplified alternatives, gaps in health education, and disparities in access to primary care services. These obstacles underscore the need for a more integrated and coordinated approach across different levels of care, with a focus on training multiprofessional teams and strengthening health education strategies targeted at families.

The implementation of the digital version of the CC, while promising, requires careful consideration. Its effectiveness will depend on the training of healthcare teams, technological accessibility, and the digital literacy of the population. This context highlights the need to adopt a comprehensive and multifaceted perspective toward the child and their family, integrating clinical, social, technological, and educational dimensions in healthcare provision. These challenges reinforce the importance of a more integrated and coordinated approach across different levels of care, with an emphasis on strengthening multiprofessional team training and expanding health education strategies aimed at families.

Moreover, the central role of PHC, with its capacity to provide continuous and equitable care, must be recognized to ensure that instruments such as the CC reach their full potential as tools for public health, surveillance, and citizenship, incorporating innovations such as the digital record without overlooking the regional and social inequalities that may hinder its effective use. Overcoming these challenges therefore demands a sustained commitment to enhancing public policies, valuing network-based work, and reinforcing health education, with the ultimate goal of ensuring that future generations have access to the comprehensive care necessary for healthy development.

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